

INCIDENT INFO	Date	MM/DD/YYYY	Inc #	Jur Sta	PD Unit #	No Pt	Cx at Scene	PuB Asst	DOA	Pronc'd by Base	IFT	Pg 2	PATIENT ASSESSMENT
Pt _____ of _____ # Pts _____ Transported _____													
Orig. Seq. # _____													
RC													
Age _____ Y _____ M _____ D _____ H _____ Gender: _____ M _____ F _____ Wt _____ lb _____ kg _____													
Peds Color Code _____ Too Tall _____													
Distress _____ Sev _____ Mod _____ Level _____ Mild _____ None _____													
Complaint { 1 2 3 4													
Mechanism of Injury { 1 2 3 4													
GCS/mLAPSS													
Time _____ Eyes _____ Motor _____ Verbal _____ GCS Total _____													
NorMal for pt / Age _____ mLAPSS _____ Met _____ Not Met _____ Last known well: _____ Date: _____ Time: _____													
SPECIAL CIRCUMSTANCES													
Barriers to Pt Care _____ Poison Control Contacted _____ Abuse Suspected _____ Reported To: _____ ETOH Suspected _____ Drugs Suspected _____													
THERAPIES													
Bk Blows/Thrust _____ TM # _____ BVM _____ Breath Sounds _____ Chest Rise _____ Existing Trach. _____ OP/NP Airway _____ Cooling Measures _____ Dressings _____ Ice Pack _____ Oxy _____ NC or M _____ REstraints _____ Distal CSM Intact _____ Spinal Immobil _____ CMS Intact - Before _____ CMS Intact - After _____ Spinal Clearance Alg. _____ SPInt _____ Traction _____ Suction _____ BLd Gluc #1 _____ #2 _____ CPAP @ _____ cm H <sub>2</sub> O _____ @ _____ time _____ FB Removal _____ IV _____ g _____ site _____ I.O. _____ g _____ site _____ Needle Thoracost _____ Vagal Maneuvers _____ TC Pacing, mA _____ @Time _____ bpm _____ Other _____													
Reassessment after Therapies and/or Condition on Transfer:													
Total IV Fluids Received: _____ ml/s													
Care Transferred To: _____ Facility _____ ALS _____ BLS _____ Heli _____ Transfer VS _____ Time _____ TM# _____ BP _____ Pulse _____ Resp _____ SpO2 _____ EKG _____ GCS _____ Signature TM completing form _____ Sig #1 _____ Sig #2 _____ Reviewed By _____													

## PATIENT RELEASE

I hereby release: \_\_\_\_\_ EMS provider and  
**Por este acto relévio** **proveedor de asistencia y**

Hospital (if base contact made) from any \_\_\_\_\_  
**hospital de posibilidad de incurrir en demanda**

liability of medical claims resulting from my refusal of emergency care and/or transportation to the nearest  
**medical resultado de mi denegación de tratamiento emergencia o transportacion a la clinica mas proxima. A mas**  
recommended medical facility. I further understand that I have been directed to contact my personal physician as to my  
**de esto, comprendo yo que me han dado instrucciones a comunicar con mi medico privado de mi estado medical**  
present condition as soon as possible. I have received an explanation of the potential consequences of my refusal  
**tan pronto como es posible. Me han explicado la importancia de mi opcion y los resultados posible por mi denegacion.**

Risks / Consequences: \_\_\_\_\_  
**Riesgos / Consecuencias:**

Reason for refusal: \_\_\_\_\_  
**Mi argumento para denegar:**

Additional comments: \_\_\_\_\_  
**Mas comentarios:**

\_\_\_\_\_  
Patient Signature  
**Firma del Paciente**

\_\_\_\_\_  
Date  
**Fecha**

\_\_\_\_\_  
Legal Representative  
**Custodio Legal**

\_\_\_\_\_  
Relationship to Patient  
**Parentesco al Paciente**

\_\_\_\_\_  
Witness 1  
**Presenciador**

\_\_\_\_\_  
Date  
**Fecha**

\_\_\_\_\_  
Witness 2  
**Presenciador**

\_\_\_\_\_  
Date  
**Fecha**

Yes

- ☐ GCS = 15  
☐ Advised of risks and consequences  
☐ Interpreter used: Name: \_\_\_\_\_  
☐ Patient has plans for follow up

Yes

- ☐ Advised alternative medical care at once  
☐ Understands consequences of refusal  
☐ Instructed to recontact 911 if patient's condition deteriorates or patient reconsiders the need for 911 assistance

Refused: ☐ Treatment  
☐ Transport

# EMS REPORT

INCIDENT INFO	Date <b>MM/DD/YYYY</b>		Inc #		Jur Sta		PD Unit #		<input type="checkbox"/> No Pt <input type="checkbox"/> Cx at Scene <input type="checkbox"/> PuB Asst <input type="checkbox"/> DOA <input type="checkbox"/> Pronc'd by Base <input type="checkbox"/> IFT <input type="checkbox"/> Pg 2				<b>PATIENT ASSESSMENT</b> Pt ____ of ____ # Pts ____ Transported Orig. Seq. # ____ <div style="font-size: 2em; color: red; font-weight: bold; margin: 5px 0;">RC</div> Age ____ <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> H Gender: <input type="checkbox"/> M <input type="checkbox"/> F Wt ____ <input type="checkbox"/> lb <input type="checkbox"/> kg <div style="border: 1px solid blue; padding: 2px; display: inline-block;">Peds Color Code <input type="checkbox"/> Too Tall</div> Distress <input type="checkbox"/> Sev <input type="checkbox"/> Mod Level <input type="checkbox"/> Mil <input type="checkbox"/> None Complaint { <span style="margin: 0 10px;">1   2</span> <span style="margin: 0 10px;">3   4</span> Mechanism of Injury { <span style="margin: 0 10px;">1   2</span> <span style="margin: 0 10px;">3   4</span>																																																																											
	Inc Loc		Street Number		Street Name		Type		Apt #		City Code						Incident Zip Code																																																																							
	Prov	A/B/H	Unit	Disp	Arrival	At Pt	Left	At Fac	Avail	Team Member ID																																																																														
																	#1	#2	#3	#4	#5	#6	#7	#8																																																																
TRANS	B. Contact		Protocol		Protocol		B. Ntfd		Rec Fac		VIA		Trans To		Reason																																																																									
	<input type="checkbox"/> AMA <input type="checkbox"/> Code 3		MAR: ____		<input type="checkbox"/> ED Sat		<input type="checkbox"/> ALS <input type="checkbox"/> BLS <input type="checkbox"/> Heli <input type="checkbox"/> No Transport		<input type="checkbox"/> MAR <input type="checkbox"/> PeriNat <input type="checkbox"/> EDAP <input type="checkbox"/> ASC <input type="checkbox"/> Other <input type="checkbox"/> SRC <input type="checkbox"/> TC/PTC <input type="checkbox"/> PMC		<input type="checkbox"/> No SC Req'd <input type="checkbox"/> SC Guide <input type="checkbox"/> Request <input type="checkbox"/> No SC Access <input type="checkbox"/> Extremis <input type="checkbox"/> Criteria <input type="checkbox"/> Guideline <input type="checkbox"/> Judgment																																																																													
PT INFO	Name/Last				First				MI		DOB / /		Phone ( )																																																																											
	Address								City		Zip		Total Mileage																																																																											
	Insurance				Hospital ID				PMD Name		Partial SS # (last 5 digits)																																																																													
COMMENTS	<div style="text-align: center; font-size: 2em; color: gray; opacity: 0.5; transform: rotate(-45deg); pointer-events: none;">             Do Not Use           </div>																																																																																							
	HX																																																																																							
	SEDs in past 48 hrs <input type="checkbox"/> Y <input type="checkbox"/> N																																																																																							
	Allergies																																																																																							
COMPLAINTS	<div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"> <b>MEDICAL</b>  <input type="checkbox"/> Abd/Pelvic Pain   <input type="checkbox"/> Cardiac Arrest   <input type="checkbox"/> Fever   <input type="checkbox"/> Near Drowning   <input type="checkbox"/> Respiratory Arrest   <input type="checkbox"/> No Medical Complaint  <input type="checkbox"/> Allergic Reaction   <input type="checkbox"/> DOA   <input type="checkbox"/> Foreign Body   <input type="checkbox"/> Neck/Back Pain   <input type="checkbox"/> SEizure   <input type="checkbox"/> Shortness of Breath   <input type="checkbox"/> Inpatient Medical  <input type="checkbox"/> A.L.T.E.   <input type="checkbox"/> Chest Pain   <input type="checkbox"/> GI Bleed   <input type="checkbox"/> NO sebleed   <input type="checkbox"/> SYNcope   <input type="checkbox"/> Other Pain  <input type="checkbox"/> Altered Loc   <input type="checkbox"/> CHoking/Airway Obst   <input type="checkbox"/> Head Pain   <input type="checkbox"/> OBstetrics   <input type="checkbox"/> WEak/Dizzy   <input type="checkbox"/> Medical Device  <input type="checkbox"/> Apnea Episode   <input type="checkbox"/> Cough/Congestion   <input type="checkbox"/> HYpoglycemia   <input type="checkbox"/> Labor   <input type="checkbox"/> NeWborn   <input type="checkbox"/> VAGinal Bleed   <input type="checkbox"/> Complaint  <input type="checkbox"/> Bleeding Oth Site   <input type="checkbox"/> DYsrhythmia   <input type="checkbox"/> Local Neuro Signs   <input type="checkbox"/> OD/POisoning   <input type="checkbox"/> Palpitations   <input type="checkbox"/> Other  <input type="checkbox"/> BEHavioral   <input type="checkbox"/> Agitated           </div> <div style="width: 33%;"> <b>TRAUMA</b>  <input type="checkbox"/> No Apparent Injury   <input type="checkbox"/> B P   <input type="checkbox"/> Traumatic Arrest   <input type="checkbox"/> Abdomen   <input type="checkbox"/> Protective Devices: <input type="checkbox"/> SeatBelt   <input type="checkbox"/> AirBag   <input type="checkbox"/> HeLmet   <input type="checkbox"/> CarSeat/Booster  <input type="checkbox"/> Burns/Elec. Shock   <input type="checkbox"/> Head   <input type="checkbox"/> GCS≤14   <input type="checkbox"/> Diffuse Abd. Tend   <input type="checkbox"/> Enclosed Veh.   <input type="checkbox"/> SPorts/Recreation   <input type="checkbox"/> Self-Inflct'd/Acc.  <input type="checkbox"/> SBP &lt;90, &lt;70 (&lt;1yr)   <input type="checkbox"/> Face/mouth   <input type="checkbox"/> Genital/Buttocks   <input type="checkbox"/> Ejected   <input type="checkbox"/> EXtricated @ ____   <input type="checkbox"/> ASsault   <input type="checkbox"/> Self-Inflct'd/Int.  <input type="checkbox"/> RR &lt;10/&gt;29, &lt;20 (&lt;1yr)   <input type="checkbox"/> Neck   <input type="checkbox"/> Extremities   <input type="checkbox"/> Pass. Space Intr. <input type="checkbox"/> &gt;12" <input type="checkbox"/> &gt;18"   <input type="checkbox"/> STabbing   <input type="checkbox"/> GSW   <input type="checkbox"/> HazMat Exposure  <input type="checkbox"/> Susp. Pelvic FX   <input type="checkbox"/> Back   <input type="checkbox"/> EXtr knee/elbow   <input type="checkbox"/> Survived Fatal Accident   <input type="checkbox"/> ANimal Bite   <input type="checkbox"/> Work-Related  <input type="checkbox"/> Spinal Cord Injury   <input type="checkbox"/> Chest   <input type="checkbox"/> FRACTures &gt; 2 long   <input type="checkbox"/> CRush   <input type="checkbox"/> Telemetry Data  <input type="checkbox"/> Inpatient Trauma   <input type="checkbox"/> Flail Chest   <input type="checkbox"/> AMP t wrist/ankle   <input type="checkbox"/> Ped/Bike Runover/Thrown/&gt;20mph   <input type="checkbox"/> FALL   <input type="checkbox"/> &gt;15ft/&gt;10ft   <input type="checkbox"/> Medical Hx  <input type="checkbox"/> Minor Lacerations   <input type="checkbox"/> Tension Pneum   <input type="checkbox"/> Neur/Vaso/Mangl'd   <input type="checkbox"/> Ped/Bike &lt;20mph   <input type="checkbox"/> Electrical Shock   <input type="checkbox"/> Anti-Coag  <input type="checkbox"/> Motorcycle/Moped   <input type="checkbox"/> Thermal Burn   <input type="checkbox"/> UNKnown   <input type="checkbox"/> OTher:           </div> </div>																																																																																							
	<b>PHYS</b> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"> <input type="checkbox"/> PERL   <input type="checkbox"/> Unequal   <input type="checkbox"/> Pinpoint   <input type="checkbox"/> Fixed &amp; Dil.   <input type="checkbox"/> Sluggish  <input type="checkbox"/> Normal   <input type="checkbox"/> Unequal   <input type="checkbox"/> JVD   <input type="checkbox"/> Normal   <input type="checkbox"/> Jaundiced   <input type="checkbox"/> Warm   <input type="checkbox"/> Cap Refill: <input type="checkbox"/> 12 LEAD TIME: <input type="checkbox"/> NL   <input type="checkbox"/> ArtiFact  <input type="checkbox"/> Clear   <input type="checkbox"/> Stridor   <input type="checkbox"/> AMU   <input type="checkbox"/> Cyanotic   <input type="checkbox"/> Hot   <input type="checkbox"/> NoRmal/   <input type="checkbox"/> ABnl   <input type="checkbox"/> Wavy Baseline  <input type="checkbox"/> Wheezes   <input type="checkbox"/> Rales   <input type="checkbox"/> Labored   <input type="checkbox"/> Pale   <input type="checkbox"/> CoLd   <input type="checkbox"/> DElayed   <input type="checkbox"/> STEMI   <input type="checkbox"/> Paced Rhythm  <input type="checkbox"/> RHonchi   <input type="checkbox"/> ShorinG   <input type="checkbox"/> Apnea   <input type="checkbox"/> Flushed   <input type="checkbox"/> Diaph           </div> </div>																																																																																							
	<b>V SIGNS</b> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th>Time</th> <th>TM#</th> <th>BP</th> <th>Pulse</th> <th>Resp</th> <th>SpO2%</th> <th>T Vol (N + -)</th> <th>Pain (0-10)</th> <th>Meds/Defib</th> <th>Dose</th> <th>Route</th> <th>Result</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>																Time	TM#	BP	Pulse	Resp	SpO2%	T Vol (N + -)	Pain (0-10)	Meds/Defib	Dose	Route	Result																																																												
	Time	TM#	BP	Pulse	Resp	SpO2%	T Vol (N + -)	Pain (0-10)	Meds/Defib	Dose	Route	Result																																																																												
ARRREST	Wit. <input type="checkbox"/> Citizen <input type="checkbox"/> EMS <input type="checkbox"/> None				Reason(s) for withholding resuscitation:				PRN Meds				MIDAZOLAM				MORPHINE																																																																							
	<input type="checkbox"/> Citizen CPR				<input type="checkbox"/> DNR/AHCD/POLST				<input type="checkbox"/> ALB <input type="checkbox"/> NTG				Given: ____ mg				Given: ____ mg																																																																							
	EMS CPR @ ____ (time)				<input type="checkbox"/> ASY> ____min   Time of 814 Death				<input type="checkbox"/> MID				Wasted: ____ mg				Wasted: ____ mg																																																																							
	Arrest to CPR: ____ (min)				<input type="checkbox"/> Rigor <input type="checkbox"/> Llividity <input type="checkbox"/> Bl. Trauma				<input type="checkbox"/> MS				Narcotic wasted: RN Witness																																																																											
<input type="checkbox"/> AED <input type="checkbox"/> Analyze <input type="checkbox"/> Defib				<input type="checkbox"/> OTher				<input type="checkbox"/> D50 <input type="checkbox"/> GLU				Name (print) ____				Signature: ____																																																																								
<input type="checkbox"/> ALS Resuscitation (use page 2)				<input type="checkbox"/> FAmily: ____ (relationship)				<input type="checkbox"/> NAR																																																																																
				(sig) ____				OT ____																																																																																
Reassessment after Therapies and/or Condition on Transfer:																																																																																								
Total IV Fluids Received: ____ ml's																																																																																								
Care Transferred To: <input type="checkbox"/> Facility				Transfer VS		Time	TM#	BP	Pulse	Resp	SpO2	EKG	GCS																																																																											
<input type="checkbox"/> ALS <input type="checkbox"/> BLS <input type="checkbox"/> Heli													E   M   V																																																																											
Signature TM completing form																																																																																								
Sig #1				Sig #2				Reviewed By																																																																																

PED. GLASGOW COMA SCALE			PEDIATRIC AGE / ASSESSMENT																																																	
<b>EYE OPENING</b> Spontaneously 4 To speech 3 To pain 2 No opening 1  <b>BEST MOTOR RESPONSE</b> Spontaneous or purposeful 6 Withdraws from touch 5 Withdraws from pain 4 Abnormal flexion 3 Abnormal extension 2 No response 1  <b>BEST VERBAL RESPONSE</b> Smiles, tracks objects 5 Cries but consolable 4 Inconsistently inconsolable, moaning 3 Inconsolable, agitated 2 No response 1			<b>PRINCIPLES:</b> 1. Pediatric patients require special consideration in assessment, treatment and administration of medication. 2. The treatment and concentration of medications are age specific for the pediatric patient. 3. For purposes of destination, pediatric patients in the prehospital setting are defined as children <b>14 years of age or younger</b> . 4. Apparent Life Threatening Event (ALTE) is defined as an episode characterized by a combination of any of the following (for children 12 months and under): • Apnea • Choking or gagging • Color change (usually cyanosis, but occasionally erythema) • Marked change in muscle tone (usually limpness)																																																	
<b>NORMAL PEDIATRIC VITAL SIGNS</b>  <table border="1"> <thead> <tr> <th></th> <th>Heart Rate</th> <th>Resp Rate</th> </tr> </thead> <tbody> <tr> <td>Infant</td> <td>100-180</td> <td>30-60</td> </tr> <tr> <td>Toddler</td> <td>80-110</td> <td>24-40</td> </tr> <tr> <td>Preschooler</td> <td>70-110</td> <td>22-23</td> </tr> <tr> <td>School-age</td> <td>60-110</td> <td>18-30</td> </tr> </tbody> </table> Normal Blood Pressure can be estimated: 90 + (2x age in years) = Systolic BP				Heart Rate	Resp Rate	Infant	100-180	30-60	Toddler	80-110	24-40	Preschooler	70-110	22-23	School-age	60-110	18-30	<b>GUIDELINES:</b> 1. A Pediatric Resuscitation Tape shall be used to obtain the patient's weight and treatment color code on all ALS pediatric patients. Pediatric patients < 12 years or < 40 kg, who require ventilatory support will be managed with BLS measures as indicated. 2. A King LTS-D may be used for pediatric patients ≥ 12 years of age. • Small Adult (Height between 4 feet and 5 feet) • Adult (Height between 5 feet and 6 feet) • Large Adult (Height 6 feet and taller) 3. Child CPR is used for patients from 1 year of age to the onset of puberty.. 4. Infant CPR is used for patients 2-13 months. 5. Neonatal CPR is used for patients newborn to 1 month of age. 6. AED may be used for all children. Pediatric pads are recommended for infants and children <8 years of age. For children ≥ 8 years of age, use a standard AED.																																		
	Heart Rate	Resp Rate																																																		
Infant	100-180	30-60																																																		
Toddler	80-110	24-40																																																		
Preschooler	70-110	22-23																																																		
School-age	60-110	18-30																																																		
<b>ECG CODES</b> <table border="1"> <thead> <tr> <th>Code</th> <th>ECG Code</th> <th>ECG Code</th> </tr> </thead> <tbody> <tr> <td>AFI</td> <td>Atrial Fibrillation</td> <td>PAC</td> </tr> <tr> <td>AFL</td> <td>Atrial Flutter</td> <td>PAT</td> </tr> <tr> <td>AGO</td> <td>Agonal Rhythm</td> <td>PEA</td> </tr> <tr> <td>ASY</td> <td>Asystole</td> <td>PST</td> </tr> <tr> <td>AVR</td> <td>Accelerated Ventricular</td> <td>PVC</td> </tr> <tr> <td>1HB</td> <td>1-Heart Block</td> <td>SR</td> </tr> <tr> <td>2HB</td> <td>2-Heart Block</td> <td>SB</td> </tr> <tr> <td>3HB</td> <td>3-Heart Block</td> <td>ST</td> </tr> <tr> <td>IV</td> <td>Idioventricular</td> <td>SVT</td> </tr> <tr> <td>JR</td> <td>Junctional Rhythm</td> <td>VF</td> </tr> <tr> <td>NSR</td> <td>Normal Sinus Rhythm</td> <td>VT</td> </tr> <tr> <td>PM</td> <td>Pacemaker</td> <td></td> </tr> </tbody> </table> <b>Monitoring Principles:</b> 1. Any patient placed on a cardiac monitor should remain on the monitor until care is transferred. 2. Any patient that requires a monitor should have a 6 second strip attached to the original and receiving facility copies of the EMS Report Form.			Code	ECG Code	ECG Code	AFI	Atrial Fibrillation	PAC	AFL	Atrial Flutter	PAT	AGO	Agonal Rhythm	PEA	ASY	Asystole	PST	AVR	Accelerated Ventricular	PVC	1HB	1-Heart Block	SR	2HB	2-Heart Block	SB	3HB	3-Heart Block	ST	IV	Idioventricular	SVT	JR	Junctional Rhythm	VF	NSR	Normal Sinus Rhythm	VT	PM	Pacemaker		<b>SPINAL IMMOBILIZATION</b>  <b>All of the following must be NO in order to transport without</b> Patient Unresponsive Not Alert / GCS < 15 Communication Barrier Recent Hx of Loss Of Conc. Suspected ETOH / Drugs Spinal Pain / Tenderness / Deformity Neurological Deficit Other Painful or Distracting Injury										
Code	ECG Code	ECG Code																																																		
AFI	Atrial Fibrillation	PAC																																																		
AFL	Atrial Flutter	PAT																																																		
AGO	Agonal Rhythm	PEA																																																		
ASY	Asystole	PST																																																		
AVR	Accelerated Ventricular	PVC																																																		
1HB	1-Heart Block	SR																																																		
2HB	2-Heart Block	SB																																																		
3HB	3-Heart Block	ST																																																		
IV	Idioventricular	SVT																																																		
JR	Junctional Rhythm	VF																																																		
NSR	Normal Sinus Rhythm	VT																																																		
PM	Pacemaker																																																			
<b>MEDICATIONS / DEFIBRILLATION</b>  <table border="1"> <thead> <tr> <th>Medications:</th> <th>Medications Routes:</th> </tr> </thead> <tbody> <tr> <td>ADE Adenosine</td> <td>IM Intramuscular</td> </tr> <tr> <td>ALB Albuterol</td> <td>IN Inhaled/Inhalation/Intranasal</td> </tr> <tr> <td>AMI Amiodarone</td> <td>IO Intraosseous</td> </tr> <tr> <td>ASA Aspirin</td> <td>IV Intravenous</td> </tr> <tr> <td>ATR Atropine</td> <td>PB Piggyback</td> </tr> <tr> <td>BEN Benadryl</td> <td>PO By Mouth</td> </tr> <tr> <td>BIC Sodium Bicarbonate</td> <td>SL Sublingual</td> </tr> <tr> <td>CAL Calcium Chloride</td> <td>SQ Subcutaneous</td> </tr> <tr> <td>D25 25% Dextrose</td> <td></td> </tr> <tr> <td>D50 50% Dextrose</td> <td><b>Dose:</b></td> </tr> <tr> <td>DOP Dopamine</td> <td>FC Fluid Challenge</td> </tr> <tr> <td>EPI Epinephrine</td> <td>TKO To Keep Open</td> </tr> <tr> <td>GLU Glucagon</td> <td>WO Wide Open</td> </tr> <tr> <td>GLP Oral Glucose Paste</td> <td></td> </tr> <tr> <td>COL Glucola</td> <td><b>Defibrillation:</b></td> </tr> <tr> <td>MAG Magnesium Sulfate Study</td> <td>CAR Cardioversion</td> </tr> <tr> <td>MID Midazolam</td> <td>DEF Defibrillation</td> </tr> <tr> <td>MS Morphine Sulfate</td> <td>TCP Transcutaneous Pacing</td> </tr> <tr> <td>NAR Narcan</td> <td></td> </tr> <tr> <td>NTG Nitroglycerin</td> <td><b>IV Access:</b> (Chart as medication)</td> </tr> <tr> <td>OND Ondansetron</td> <td>NS Normal Saline</td> </tr> <tr> <td></td> <td>SL Saline Lock</td> </tr> <tr> <td></td> <td>IVU IV Unobtainable</td> </tr> </tbody> </table>			Medications:	Medications Routes:	ADE Adenosine	IM Intramuscular	ALB Albuterol	IN Inhaled/Inhalation/Intranasal	AMI Amiodarone	IO Intraosseous	ASA Aspirin	IV Intravenous	ATR Atropine	PB Piggyback	BEN Benadryl	PO By Mouth	BIC Sodium Bicarbonate	SL Sublingual	CAL Calcium Chloride	SQ Subcutaneous	D25 25% Dextrose		D50 50% Dextrose	<b>Dose:</b>	DOP Dopamine	FC Fluid Challenge	EPI Epinephrine	TKO To Keep Open	GLU Glucagon	WO Wide Open	GLP Oral Glucose Paste		COL Glucola	<b>Defibrillation:</b>	MAG Magnesium Sulfate Study	CAR Cardioversion	MID Midazolam	DEF Defibrillation	MS Morphine Sulfate	TCP Transcutaneous Pacing	NAR Narcan		NTG Nitroglycerin	<b>IV Access:</b> (Chart as medication)	OND Ondansetron	NS Normal Saline		SL Saline Lock		IVU IV Unobtainable	<b>GLASGOW COMA SCALE</b>  <b>EYE OPENING</b> Spontaneously 4 To Verbal Command 3 To Pain 2 No Response 1  <b>BEST MOTOR RESPONSE</b> Obedient 6 Purposeful 5 Withdrawal 4 Flexion 3 Extension 2 No Response 1  <b>BEST VERBAL RESPONSE</b> Oriented 5 Confused 4 Inappropriate Words 3 Incomprehensible Sounds 2 No Response 1	<b>Modified Los Angeles Prehospital Stroke Screen (mLAPSS)</b>  <b>MODIFIED LAPSS CRITERIA</b> 1. Symptoms less than 2 hours duration 2. No history of seizures or epilepsy 3. Age equal to or greater than 40 years 4. At baseline, not wheelchair bound or bedridden 5. Blood glucose between 60 and 400 mg/dl 6. Motor Exam: Examine for obvious asymmetry (positive if one or more of the following is met) a. Facial Smile/Grimace b. Grip c. Arm Strength
Medications:	Medications Routes:																																																			
ADE Adenosine	IM Intramuscular																																																			
ALB Albuterol	IN Inhaled/Inhalation/Intranasal																																																			
AMI Amiodarone	IO Intraosseous																																																			
ASA Aspirin	IV Intravenous																																																			
ATR Atropine	PB Piggyback																																																			
BEN Benadryl	PO By Mouth																																																			
BIC Sodium Bicarbonate	SL Sublingual																																																			
CAL Calcium Chloride	SQ Subcutaneous																																																			
D25 25% Dextrose																																																				
D50 50% Dextrose	<b>Dose:</b>																																																			
DOP Dopamine	FC Fluid Challenge																																																			
EPI Epinephrine	TKO To Keep Open																																																			
GLU Glucagon	WO Wide Open																																																			
GLP Oral Glucose Paste																																																				
COL Glucola	<b>Defibrillation:</b>																																																			
MAG Magnesium Sulfate Study	CAR Cardioversion																																																			
MID Midazolam	DEF Defibrillation																																																			
MS Morphine Sulfate	TCP Transcutaneous Pacing																																																			
NAR Narcan																																																				
NTG Nitroglycerin	<b>IV Access:</b> (Chart as medication)																																																			
OND Ondansetron	NS Normal Saline																																																			
	SL Saline Lock																																																			
	IVU IV Unobtainable																																																			
<b>FLACC (Face, Legs, Activity, Cry and Consolability) (&lt; 3 yrs or with cognitive impairment)</b> <table border="1"> <thead> <tr> <th>Behavior</th> <th>0</th> <th>1</th> <th>2</th> </tr> </thead> <tbody> <tr> <td><b>F</b> Face</td> <td>No particular expression or smile</td> <td>Occasional grimace or frown, withdrawn, disinterested</td> <td>Frequent to constant frown, clenched jaw, quivering chin</td> </tr> <tr> <td><b>L</b> Legs</td> <td>Normal position or relaxed</td> <td>Uneasy, restless, tense</td> <td>Kicking or legs drawn up</td> </tr> <tr> <td><b>A</b> Activity</td> <td>Lying quietly, normal position, moves easily</td> <td>Squirming, tense, shifting back and forth, hesitant to move, guarding</td> <td>Arched, rigid or jerking, fixed position, rubbing of body part</td> </tr> <tr> <td><b>C</b> Cry</td> <td>No cry/ moan (awake or asleep)</td> <td>Moans or whispers, occasional cries, sighs or complaint</td> <td>Cries steadily, screams, sobs, moans, groans, frequent complaints</td> </tr> <tr> <td><b>C</b> Consolability</td> <td>Calm, content, relaxed, needs no consoling</td> <td>Reassured by hugging, talking to, distractible</td> <td>Difficult to console or comfort</td> </tr> </tbody> </table>			Behavior	0	1	2	<b>F</b> Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant frown, clenched jaw, quivering chin	<b>L</b> Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking or legs drawn up	<b>A</b> Activity	Lying quietly, normal position, moves easily	Squirming, tense, shifting back and forth, hesitant to move, guarding	Arched, rigid or jerking, fixed position, rubbing of body part	<b>C</b> Cry	No cry/ moan (awake or asleep)	Moans or whispers, occasional cries, sighs or complaint	Cries steadily, screams, sobs, moans, groans, frequent complaints	<b>C</b> Consolability	Calm, content, relaxed, needs no consoling	Reassured by hugging, talking to, distractible	Difficult to console or comfort	<b>PAIN SCALE (Document on all patients complaining of pain and after all medications for the relief of pain)</b>   0 1 2 3 4 5 6 7 8 9 10 No Pain Some Discomfort Having Discomfort Mild Pain Moderate Pain Severe Pain Most Severe Pain																									
Behavior	0	1	2																																																	
<b>F</b> Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant frown, clenched jaw, quivering chin																																																	
<b>L</b> Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking or legs drawn up																																																	
<b>A</b> Activity	Lying quietly, normal position, moves easily	Squirming, tense, shifting back and forth, hesitant to move, guarding	Arched, rigid or jerking, fixed position, rubbing of body part																																																	
<b>C</b> Cry	No cry/ moan (awake or asleep)	Moans or whispers, occasional cries, sighs or complaint	Cries steadily, screams, sobs, moans, groans, frequent complaints																																																	
<b>C</b> Consolability	Calm, content, relaxed, needs no consoling	Reassured by hugging, talking to, distractible	Difficult to console or comfort																																																	





## RECEIVING FACILITIES

(Base Hospitals are noted in Bold)

ACH Alhambra Hospital  
ANH Anaheim Memorial Hospital (Orange Co.)  
**AVH Antelope Valley Medical Center**  
AHM Catalina Island Medical Center  
ARM Arrowhead Regional Medical Center (SB County)  
BEL Bellflower Medical Center  
BEV Beverly Hospital  
BMC Brotman Medical Center  
**CAL California Hospital Medical Center**  
**CSM Cedars-Sinai Hospital Medical Center**  
CNT Centinela Hospital Medical Center  
CHH Childrens Hospital Los Angeles  
CHI Chino Valley Medical Center (San Bernardino Co)  
ICH Citrus Valley Medical Center-Intercommunity Campus  
**QVH Citrus Valley Medical Center-Queen of the Valley Campus**  
CPM Coast Plaza Doctors Hospital  
CHP Community Hospital of Huntington Park  
LBC Community Hospital of Long Beach  
DFM Marina Del Rey Hospital  
DHM Doctors Hospital Medical Center of Montclair (San Bernardino Co)  
DCH Downey Regional Medical Center  
ELA East Los Angeles Doctors Hospital  
HEV East Valley Hospital  
ENH Encino Hospital Medical Center  
TRM Providence Tarzana Medical Center  
FPH Foothill Presbyterian Hospital  
GAR Garfield Medical Center  
**GWT Glendale Adventist Medical Center**  
GMH Glendale Memorial Hospital/Health Center  
GSH Good Samaritan Hospital  
GEM Greater El Monte Community Hospital  
**HGH Harbor-UCLA Medical Center**  
**HMN Henry Mayo Newhall Memorial Hospital**  
**HMH Huntington Memorial Hospital**  
KFA Kaiser Foundation - Baldwin Park  
KFB Kaiser Foundation - Downey  
KFF Kaiser Foundation - Fontana (San Bernardino Co.)  
KFH Kaiser Foundation - South Bay  
KFL Kaiser Foundation - Los Angeles  
KFN Kaiser Foundation - Ontario (San Bernardino Co)  
KFP Kaiser Foundation - Panorama City  
KFW Kaiser Foundation - West Los Angeles  
KFO Kaiser Foundation - Woodland Hills  
KHA Kaiser Hospital Anaheim (Orange Co.)  
LPI La Palma Intercommunity Hospital (Orange Co)  
OVM LAC Olive View Medical Center  
**USC LAC+USC Medical Center**  
DHL Lakewood Regional Medical Center  
LCH Palmdale Regional Medical Center  
**LCM Providence Little Company of Mary Hospital**  
**LBM Long Beach Memorial Medical Center**  
LAD Los Angeles Metropolitan Medical Center  
LAG Los Alamitos Medical Center (Orange Co)  
NOR Los Angeles Community Hospital of Norwalk  
LRR Los Robles Regional (Ventura Co.)  
MHG Memorial Hospital of Gardena  
**AMH Methodist Hospital of Southern California**  
MPH Monterey Park Hospital  
**NRH Northridge Hospital Medical Center**  
MCP Mission Community Hospital  
MID Olympia Medical Center  
OTH Other Hospital Not on List  
PLB Pacific Hospital of Long Beach  
PAC Pacifica Hospital of the Valley  
PLH Placentia Linda (Orange County)  
**PVC Pomona Valley Hospital Medical Center**

**PIH Presbyterian Intercommunity Hospital**  
**HCH Providence Holy Cross Medical Center**  
**SJS Providence Saint Joseph Medical Center**  
QOA Queen of Angels/Hollywood Presbyterian Medical Center  
RCC Ridgecrest Community Hospital (Kern Co.)  
**SFM Saint Francis Medical Center**  
SJH Saint John's Health Center  
SJO Saint John's Regional Medical Center (Ventura Co)  
SJD Saint Jude Medical Center (Orange Co)  
**SMM Saint Mary Medical Center**  
SAC San Antonio Community Hospital (San Bernardino Co)  
SDC San Dimas Community Hospital  
SGC San Gabriel Valley Medical Center  
SPP Providence LCM San Pedro Hospital  
SMH Santa Monica-UCLA Medical Center  
SOC Sherman Oaks Community Hospital  
**TOR Torrance Memorial Medical Center**  
TRI Tri-City Regional Medical Center  
UCI UCI Medical Center (Orange Co)  
**UCL Ronald Reagan UCLA Medical Center**  
VPH Valley Presbyterian Hospital  
VHH Verdugo Hills Hospital  
HWH West Hills Hospital and Medical Center  
WMH White Memorial Hospital  
WHH Whittier Hospital Medical Center

## CONTACT CODES

GNA Contact Not Attempted  
MAC Medical Alert Center  
PRO Protocol Run

## AMBULANCE CODES

AI Air Force Plant 42  
AE Aegis  
AU AmbuServe  
AC Americare  
AR AMR  
AN Antelope Ambulance Service  
BO Bowers  
CA Care Ambulance  
EA Emergency Amb Serv  
GC Gentle Care Transport  
GE Gerber  
GU Guardian  
IA Impulse Ambulance  
LT Liberty Ambulance  
MA Mauran  
MT MedCoast Ambulance  
MR Med Reach  
MP MedResponse, Inc.  
ME Mercy Ambulance  
PT Priority One  
PM PRN Medical Transport  
RR Rescue Services  
SC Schaefer  
SY Symons Ambulance (Special Events Only)  
TR Trinity Ambulance Service  
UC UCLA Emer Med Serv  
WE West Coast Ambulance  
WM Westmed/McCormick Ambulance  
OT Other

## HELICOPTER CODES

CF LA County Fire  
CG US Coast Guard  
CI LA City Fire Dept  
CS LA Co Sheriff Dept  
RE REACH Air Medical Services  
OH Other Helicopter  
MY Mercy Air Ambulance  
UF Upland Fire  
VC Ventura Co Sheriff Dept

## CITY CODES

AG Agoura Hills  
AL Alhambra  
AD Altadena  
AR Arcadia  
AT Artesia  
AV Avalon  
AZ Azusa  
BP Baldwin Park  
BL Bell  
BG Bell Gardens  
BE Bellflower  
BH Beverly Hills  
BR Bradbury  
BU Burbank  
CB Calabasas  
CA Carson  
CT Century City  
CE Cerritos  
CH Chatsworth  
CL Claremont  
CO Commerce  
CM Compton  
CV Covina  
CR Crenshaw  
CU Cudahy  
CC Culver City  
DB Diamond Bar  
DO Downey  
DU Duarte  
ER Eagle Rock  
EM El Monte  
ES El Segundo  
EN Encino  
GA Gardena  
GL Glendale  
GW Glendora  
GV Glenview  
GR Gorman  
GH Granada Hills  
HC Hacienda Heights  
HG Hawaiian Gardens  
HA Hawthorne  
HB Hermosa Beach  
HH Hidden Hills  
HI Highland Park  
HO Hollywood  
HP Huntington Park  
IN Industry  
IG Inglewood  
IR Irwindale  
LC La Canada/Flintridge  
LR La Crescenta  
LH La Habra Hghts  
LL Lake Los Angeles  
LM La Mirada  
LP La Puente  
LV La Verne  
LK Lakewood  
LT Lancaster  
LN Lawndale  
LO Lomita  
LB Long Beach  
LA Los Angeles  
LY Lynwood  
MA Malibu  
MC Malibu Beach

MB Manhattan Beach  
MD Marina del Rey  
MW Maywood  
MN Montrose  
MV Monrovia  
MO Montebello  
MP Monterey Park  
MT Montclair  
NE Newhall  
NH North Hollywood  
NR Northridge  
NO Norwalk  
PP Palos Verdes Peninsula  
PC Pacoima  
PD Palmdale  
PV Palos Verdes Est  
PM Paramount  
PA Pasadena  
PR Pico Rivera  
PY Playa del Rey  
PO Pomona  
QH Quartz Hill  
RP Rancho P V  
RB Redondo Beach  
RS Reseda  
RH Rolling Hills  
RE Rolling Hills Est  
RM Rosemead  
RL Rowland Heights  
SD San Dimas  
SF San Fernando  
SG San Gabriel  
SN San Marino  
SR San Pedro  
SC Santa Clarita  
SS Santa Fe Springs  
SM Santa Monica  
SA Saugus  
SK Sherman Oaks  
SI Sierra Madre  
SH Signal Hill  
SE South El Monte  
SO South Gate  
SP South Pasadena  
ST Studio City  
SU Sunland  
SV Stevenson Ranch  
SY Sylmar  
TA Tarzana  
TC Temple City  
TP Topanga  
TO Torrance  
TU Tujunga  
UC Universal City  
VA Valencia  
VN Van Nuys  
VC Venice  
VE Vernon  
WA Walnut  
WC West Covina  
WE West Hills  
WH West Hollywood  
WV Westlake Village  
WW Westwood  
WI Whittier  
WM Wilmington  
WL Woodland Hills  
OT Other

# EMS REPORT

INCIDENT INFO	Date / /		Inc #		Jur Sta		PD Unit #		<input type="checkbox"/> No Pt <input type="checkbox"/> Cx at Scene <input type="checkbox"/> PuB Asst <input type="checkbox"/> DOA <input type="checkbox"/> Pronc'd by Base <input type="checkbox"/> IFT <input type="checkbox"/> Pg 2				PATIENT ASSESSMENT					
	Inc Loc		Street Number		Street Name		Type		Apt #		City Code		Incident Zip Code		Pt of # Pts			
	Prov		A/B/H		Unit		Disp		Arrival		At Pt		Left		At Fac			
	Avail		Team Member ID		#1		#2		#3		#4		#5		#6			
TRANS	B. Contact		Protocol		Protocol		B. Ntfd		Rec Fac		VIA		Trans To		Reason			
	<input type="checkbox"/> AMA <input type="checkbox"/> Code 3		MAR: _ _ _		<input type="checkbox"/> ED Sat		<input type="checkbox"/> ALS <input type="checkbox"/> BLS <input type="checkbox"/> Heli <input type="checkbox"/> No Transport		<input type="checkbox"/> MAR <input type="checkbox"/> PeriNat <input type="checkbox"/> EDAP <input type="checkbox"/> ASC <input type="checkbox"/> Other <input type="checkbox"/> SRC <input type="checkbox"/> TC/PTC <input type="checkbox"/> PMC		<input type="checkbox"/> No SC Req'd <input type="checkbox"/> SC Guide <input type="checkbox"/> Request <input type="checkbox"/> No SC Access <input type="checkbox"/> EXTremis <input type="checkbox"/> Criteria <input type="checkbox"/> Guideline <input type="checkbox"/> Judgment		Peds Color Code <input type="checkbox"/> Too Tall Distress <input type="checkbox"/> Sev <input type="checkbox"/> Mod Level <input type="checkbox"/> Mild <input type="checkbox"/> None					
PT INFO	Name/Last		First		MI		DOB / /		Phone ( )		Address		City		Zip			
	Insurance		Hospital ID		PMD Name		Partial SS # (last 5 digits)		Total Mileage		Complaint {		Mechanism of Injury {					
COMMENTS																		
MEDICAL COMPLAINTS	<input type="checkbox"/> Abd/Pelvic Pain <input type="checkbox"/> Allergic Reaction <input type="checkbox"/> A.L.T.E. <input type="checkbox"/> Altered Loc <input type="checkbox"/> Apnea Episode <input type="checkbox"/> Bleeding Oth Site <input type="checkbox"/> BEHAVioral <input type="checkbox"/> Agitated		<input type="checkbox"/> Cardiac Arrest <input type="checkbox"/> DOA <input type="checkbox"/> Chest Pain <input type="checkbox"/> CHoking/Airway Obst <input type="checkbox"/> Cough/Congestion <input type="checkbox"/> DYsrhythmia		<input type="checkbox"/> FEver <input type="checkbox"/> Foreign Body <input type="checkbox"/> GI Bleed <input type="checkbox"/> Head Pain <input type="checkbox"/> HYPoglycemia <input type="checkbox"/> Local Neuro Signs <input type="checkbox"/> Nausea/Vomiting		<input type="checkbox"/> Near Drowning <input type="checkbox"/> Neck/Back Pain <input type="checkbox"/> NOsebleed <input type="checkbox"/> OBstetrics <input type="checkbox"/> Labor <input type="checkbox"/> NeWborn <input type="checkbox"/> OD/POisoning <input type="checkbox"/> Palpitations		<input type="checkbox"/> Respiratory Arrest <input type="checkbox"/> SEizure <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> SYNcope <input type="checkbox"/> WEak/Dizzy <input type="checkbox"/> VAGinal Bleed <input type="checkbox"/> Other		<input type="checkbox"/> No Medical Complaint <input type="checkbox"/> Inpatient Medical <input type="checkbox"/> Other Pain <input type="checkbox"/> Medical Device <input type="checkbox"/> Complaint <input type="checkbox"/> Other							
	<input type="checkbox"/> No Apparent Injury <input type="checkbox"/> BUrns/Elec. Shock <input type="checkbox"/> SBP <90, <70 (<1yr) <input type="checkbox"/> RR <10/>29, <20 (<1yr) <input type="checkbox"/> Susp. Pelvic FX <input type="checkbox"/> Spinal Cord Injury <input type="checkbox"/> Inpatient Trauma <input type="checkbox"/> Minor Lacerations		B P <input type="checkbox"/> Traumatic Arrest <input type="checkbox"/> Head <input type="checkbox"/> GCS≤14 <input type="checkbox"/> Face/mouth <input type="checkbox"/> Neck <input type="checkbox"/> Back <input type="checkbox"/> Chest <input type="checkbox"/> Flail Chest <input type="checkbox"/> Tension Pneum		B P <input type="checkbox"/> Abdomen <input type="checkbox"/> Diffuse Abd. Tend <input type="checkbox"/> Genital/Buttocks <input type="checkbox"/> Extremities <input type="checkbox"/> EXtr ↑ knee/elbow <input type="checkbox"/> Fractures > 2 long <input type="checkbox"/> Amp ↑ wrist/ankle <input type="checkbox"/> Neur/Vaso/Mangl'd		Protective Devices: <input type="checkbox"/> SeatBelt <input type="checkbox"/> AirBag <input type="checkbox"/> HeLmet <input type="checkbox"/> CarSeat/Booster <input type="checkbox"/> Enclosed Veh. <input type="checkbox"/> Ejected <input type="checkbox"/> EXtricated @ <input type="checkbox"/> Pass. Space Intr. <input type="checkbox"/> >12" <input type="checkbox"/> >18" <input type="checkbox"/> Survived Fatal Accident <input type="checkbox"/> Impact >20 mph unenclosed <input type="checkbox"/> Ped/Bike Runover/Thrown/>20mph <input type="checkbox"/> Ped/Bike <20mph <input type="checkbox"/> Motorcycle/Moped		<input type="checkbox"/> SPorts/Recreation <input type="checkbox"/> ASsault <input type="checkbox"/> STabbing <input type="checkbox"/> GSW <input type="checkbox"/> ANimal Bite <input type="checkbox"/> CRush <input type="checkbox"/> Fall <input type="checkbox"/> >15ft/>10ft <input type="checkbox"/> Electrical Shock <input type="checkbox"/> Thermal Burn		<input type="checkbox"/> Self-Inflict'd/Acc. <input type="checkbox"/> Self-Inflict'd/Int. <input type="checkbox"/> HazMat Exposure <input type="checkbox"/> Work-Related <input type="checkbox"/> Telemetry Data <input type="checkbox"/> Medical Hx <input type="checkbox"/> Anti-Coag <input type="checkbox"/> UNknown <input type="checkbox"/> OTher							
	<input type="checkbox"/> PERL <input type="checkbox"/> Unequal <input type="checkbox"/> Pinpoint <input type="checkbox"/> Fixed & Dil. <input type="checkbox"/> Sluggish		RESP <input type="checkbox"/> Normal <input type="checkbox"/> Unequal <input type="checkbox"/> JVD <input type="checkbox"/> Clear <input type="checkbox"/> Stridor <input type="checkbox"/> AMU <input type="checkbox"/> Wheezes <input type="checkbox"/> Rales <input type="checkbox"/> Labored <input type="checkbox"/> RHonchi <input type="checkbox"/> ShorinG <input type="checkbox"/> Apnea		SKIN <input type="checkbox"/> Normal <input type="checkbox"/> Jaundiced <input type="checkbox"/> Warm <input type="checkbox"/> Cap Refill: <input type="checkbox"/> Cyanotic <input type="checkbox"/> Hot <input type="checkbox"/> NoRmal/ <input type="checkbox"/> Pale <input type="checkbox"/> CoLd <input type="checkbox"/> DElayed <input type="checkbox"/> Flushed <input type="checkbox"/> Diaph		12 LEAD TIME: <input type="checkbox"/> NL <input type="checkbox"/> ArtiFact <input type="checkbox"/> ABnl <input type="checkbox"/> Wavy Baseline <input type="checkbox"/> STEMI <input type="checkbox"/> Paced Rhythm											
	Time   TM#   BP   Pulse   Resp   SpO2%   T Vol (N + -)   Pain (0-10)		MEDS / DEFIB		Time   TM#   Rhythm   Meds/Defib   Dose   Route   Result													
ARRREST	Wit. <input type="checkbox"/> Citizen <input type="checkbox"/> EMS <input type="checkbox"/> None <input type="checkbox"/> Citizen CPR EMS CPR @ (time) <input type="checkbox"/> Arrest to CPR: (min) <input type="checkbox"/> AED <input type="checkbox"/> Analyze <input type="checkbox"/> Defib <input type="checkbox"/> ALS Resuscitation (use page 2)		Reason(s) for withholding resuscitation: <input type="checkbox"/> DNR/AHCD/POLST <input type="checkbox"/> ASY> min Time of 814 Death <input type="checkbox"/> Rigor <input type="checkbox"/> Llividity <input type="checkbox"/> Bl. Trauma <input type="checkbox"/> OTher <input type="checkbox"/> FAmily: (relationship) (sig)		PRN Meds <input type="checkbox"/> ALB <input type="checkbox"/> NTG <input type="checkbox"/> MID <input type="checkbox"/> MS <input type="checkbox"/> D50 <input type="checkbox"/> GLU <input type="checkbox"/> NAR <input type="checkbox"/> OT		<input type="checkbox"/> MIDAZOLAM Given: mg   Wasted: mg Narcotic wasted: RN Witness Name (print) Signature:		<input type="checkbox"/> MORPHINE Given: mg   Wasted: mg Signature:									
	Reassessment after Therapies and/or Condition on Transfer:																	
	Care Transferred To: <input type="checkbox"/> Facility <input type="checkbox"/> ALS <input type="checkbox"/> BLS <input type="checkbox"/> Heli		Transfer VS		Time   TM#   BP   Pulse   Resp   SpO2   EKG   GCS		Total IV Fluids Received: ml's											
	Signature TM completing form   Sig #1   Sig #2   Reviewed By																	

MULTICASUALTY INCIDENT

Name: _____ Triage Tag # _____ Age _____ Sex _____ Wt _____	<input type="checkbox"/> Immediate <input type="checkbox"/> Delayed <input type="checkbox"/> Minor <input type="checkbox"/> DOA	Injuries:	Resp: _____ Pulse: _____ Cap Refill: _____ <input type="checkbox"/> < 2 seconds <input type="checkbox"/> > 2 seconds GCS: _____	Treatment:	Receiving Facility: _____ ETA/Unit _____ / _____
Name: _____ Triage Tag # _____ Age _____ Sex _____ Wt _____	<input type="checkbox"/> Immediate <input type="checkbox"/> Delayed <input type="checkbox"/> Minor <input type="checkbox"/> DOA	Injuries:	Resp: _____ Pulse: _____ Cap Refill: _____ <input type="checkbox"/> < 2 seconds <input type="checkbox"/> > 2 seconds GCS: _____	Treatment:	Receiving Facility: _____ ETA/Unit _____ / _____
Name: _____ Triage Tag # _____ Age _____ Sex _____ Wt _____	<input type="checkbox"/> Immediate <input type="checkbox"/> Delayed <input type="checkbox"/> Minor <input type="checkbox"/> DOA	Injuries:	Resp: _____ Pulse: _____ Cap Refill: _____ <input type="checkbox"/> < 2 seconds <input type="checkbox"/> > 2 seconds GCS: _____	Treatment:	Receiving Facility: _____ ETA/Unit _____ / _____
Name: _____ Triage Tag # _____ Age _____ Sex _____ Wt _____	<input type="checkbox"/> Immediate <input type="checkbox"/> Delayed <input type="checkbox"/> Minor <input type="checkbox"/> DOA	Injuries:	Resp: _____ Pulse: _____ Cap Refill: _____ <input type="checkbox"/> < 2 seconds <input type="checkbox"/> > 2 seconds GCS: _____	Treatment:	Receiving Facility: _____ ETA/Unit _____ / _____
Name: _____ Triage Tag # _____ Age _____ Sex _____ Wt _____	<input type="checkbox"/> Immediate <input type="checkbox"/> Delayed <input type="checkbox"/> Minor <input type="checkbox"/> DOA	Injuries:	Resp: _____ Pulse: _____ Cap Refill: _____ <input type="checkbox"/> < 2 seconds <input type="checkbox"/> > 2 seconds GCS: _____	Treatment:	Receiving Facility: _____ ETA/Unit _____ / _____
Name: _____ Triage Tag # _____ Age _____ Sex _____ Wt _____	<input type="checkbox"/> Immediate <input type="checkbox"/> Delayed <input type="checkbox"/> Minor <input type="checkbox"/> DOA	Injuries:	Resp: _____ Pulse: _____ Cap Refill: _____ <input type="checkbox"/> < 2 seconds <input type="checkbox"/> > 2 seconds GCS: _____	Treatment:	Receiving Facility: _____ ETA/Unit _____ / _____
Name: _____ Triage Tag # _____ Age _____ Sex _____ Wt _____	<input type="checkbox"/> Immediate <input type="checkbox"/> Delayed <input type="checkbox"/> Minor <input type="checkbox"/> DOA	Injuries:	Resp: _____ Pulse: _____ Cap Refill: _____ <input type="checkbox"/> < 2 seconds <input type="checkbox"/> > 2 seconds GCS: _____	Treatment:	Receiving Facility: _____ ETA/Unit _____ / _____